

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25591	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph Robert Bunting Jr.										2a. DATE KNOWN OF DEATH ESTIMATED 9 10 1983	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1949		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.		7c. DATE PRONOUNCED DEAD 9 10 1983		2b. HOUR 12:56 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County, MD.					
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carey Rd. west of Rt. 113				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Poultry			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Carey Road		21811	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph R. Bunting, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Pardons	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-52-0348		17. INFORMANT ADDRESS Patricia H. Bunting Berlin, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries 8415 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NOON M. 9 10 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pilot in airplane crash					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Carey Rd w. of Rt. 113 Worcester, Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 9/10/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-12-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Delaware			
24. FUNERAL DIRECTOR NAME Ulrich Funeral Home				ADDRESS Berlin, Md.				25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO THE DIRECTOR OF THE
BUREAU OF THE ARMY
WASHINGTON, D. C.

FROM THE
[illegible]
[illegible]

SUBJECT: [illegible]

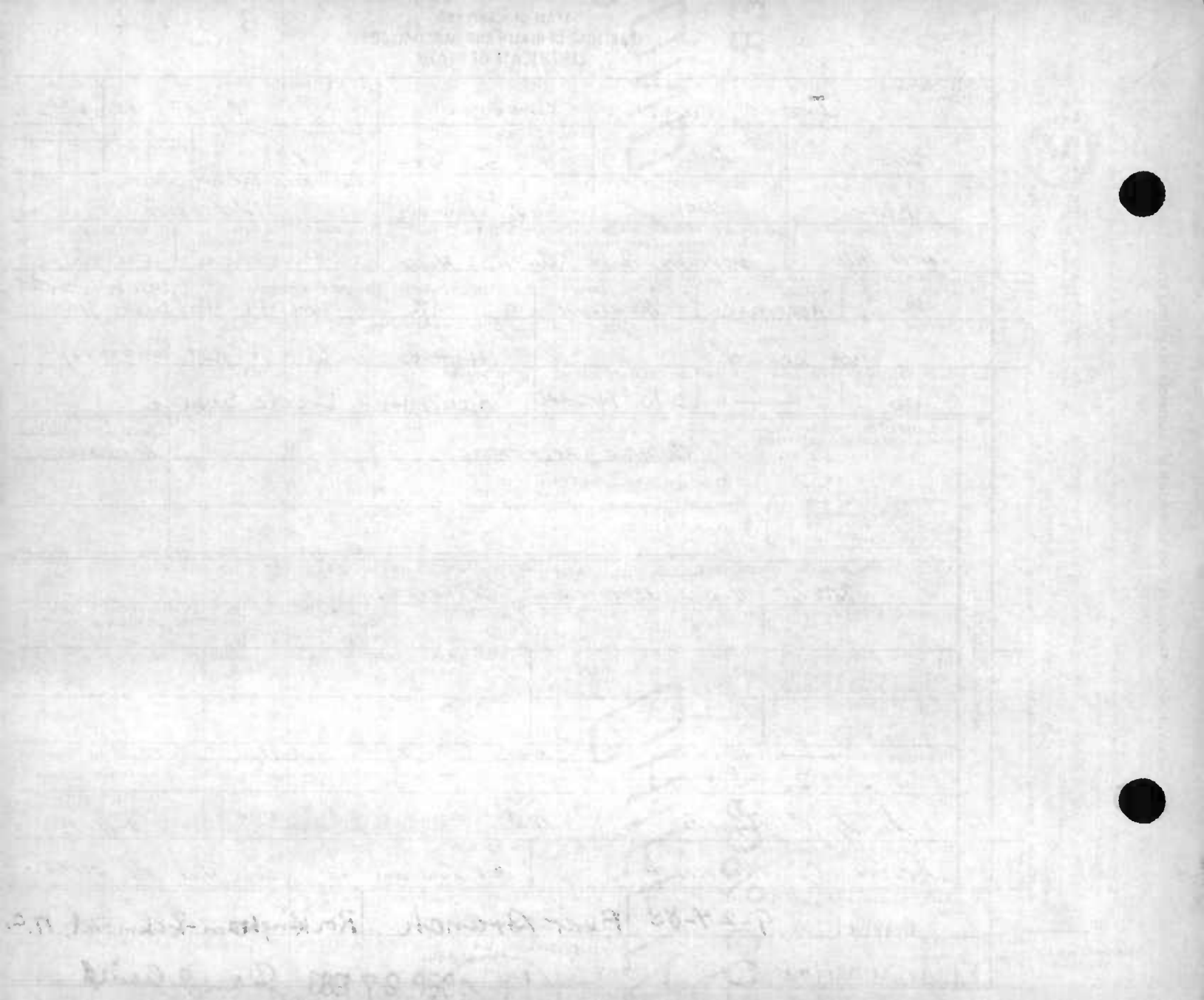
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST JAMES RUPUS COVINGTON		MALE		BLACK	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR 9 26 1894		88 YRS.		WORCESTER MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
USA -		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
SNOW HILL		HARRISON HOUSE NURSING HOME		Farmer Farming	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD.		Accomac		Hornstown	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Box 49 Hornstown, VA	
not known		Hattie (rest not known)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT	
no		240-14-5220		daughter - Lizzie Savage	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					
4275 DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
RECENT E. COLI SEPTICEMIA, DEHYDRATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5-12, 19 73, to 9-17, 19 73, that (I) (we) lost saw the deceased alive on 9-16, 19 73, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.		22b. DATE SIGNED		22c. DATE SIGNED	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Lorothy C. Holzworth		M.D.		9-17-73	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
MROTHY C. HOLZWORTH		309 Timmons St SNOW HILL, MD. 21763		9-17-73	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9-24-83		Bear Branch	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. LOCATION CITY OR TOWN COUNTY STATE	
Edgar Wharton F.H.		Accomac, VA Box 97 Rt. 1 23301		Rockingham-Richmond, N.S.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR	
SEP 27 1983		J. J. Conner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25593	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
CECIL Hope DERBY						9 1 83			10:25 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		12 27 10		72 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.				WORCESTER COUNTY MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Pocomoke			HARTLEY NALL Nursing Home			RET. RAILROAD					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
VIRGINIA			Accomac			SAYLS			Bx 93		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Will Derby			Blanche			NO			706-01-2324		
17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2089			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Robert Martin Sayles, Jr. 23427			SEPSIS								
			DUE TO, OR AS A CONSEQUENCE OF (b) Leukemia								
			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-15, 19-83, to 9-1, 19-83, that (I) (we) last saw the deceased alive on 8-27, 19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
Paul R. Flourey						9/1/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
Paul R. Flourey			305 10th St Pocomoke Md								
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			9-3-1983			Linton			Sxms. Accomack Co. R		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Felix Funeral Home			SEP 15 1983			Shan e. Carver					

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#13, Film G584 10/31/83 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 5 5 9 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE M. HUFFMAN			2a. DATE OF DEATH MONTH DAY YEAR 9 11 83		2b. HOUR 2:15 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 23 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY MD.				
10. CITY OR TOWN OF DEATH BERLIN, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		
12b. KIND OF BUSINESS OR INDUSTRY SEAMSTRESS		13a. STREET ADDRESS 734 N. Surf Rd. BERLIN MD. 21842				
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL F. DIXON				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARABELLA DIXON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 220-09-4809		17. INFORMANT ADDRESS G.E. THOMPSON OCEAN CITY				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4408 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MIOS. DUE TO, OR AS A CONSEQUENCE OF (c) Ag 119						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION Jan 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MIOS.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3 Bay St Berlin Md 21811		
22a. I certify that (I) (this hospital) attended the deceased from Jan 83 , 19 83 , to Sept 83 , that (I) (we) lost saw the deceased alive on 1 Sept 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE F. G. Arther - M.D.		DEGREE M.D.		22c. DATE SIGNED 12-19-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. G. Arther - M.D.		22e. ADDRESS 3 Bay St Berlin Md 21811				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 9-12-83		23c. NAME OF CEMETERY OR CREMATORY DELMARVA		
23d. LOCATION CITY OR TOWN COUNTY STATE LAVERG, SUSSEX DEL		24. FUNERAL DIRECTOR NAME ADDRESS VELLICK F. H. BERLIN MD.				
25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE John J. Connel				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 25595			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY W. TULL				2a. DATE OF DEATH MONTH DAY YEAR SEPT. 18 83		2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 14 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 86 3 4	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LEMOUNT VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD	
10. CITY OR TOWN OF DEATH POCOMOKE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RESIDENCE RTE 13		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD.		13b. COUNTY WOR.		13c. CITY OR TOWN POCOMOKE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM TULL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-14-0205		17. INFORMANT ADDRESS MRS. MAUDE TULL RT# Bx212 POCOMOKE			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION 9/16/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 7, 19 80, to 9, 19 83, that (1) (we) last saw the deceased alive on 9/16, 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED 9/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RITCHIE C. Stumacher MD				22e. ADDRESS PO Box 25 Pocomoke			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE SEPT. 21, 1983		23c. NAME OF CEMETERY OR CREMATORY GOODWILL ME. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE POCOMOKE WOR. MD.	
24. FUNERAL DIRECTOR NAME Scott S. Melson				ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 26 1983	
				25b. REGISTRAR'S SIGNATURE [Signature]			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO. 25597						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHRYN L. WINGATE					2a. DATE OF DEATH MONTH DAY YEAR 9/14 83			2b. HOUR 12 Noon M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Usa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY MD.					
10. CITY OR TOWN OF DEATH BERLIN, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland					13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Stansbury Scott					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie West					13e. STREET ADDRESS Esham Drive 21811	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-36-5261		17. INFORMANT ADDRESS Levi Lewis Jr. Salisbury, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Arrest.</u> 4241 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PSUD - AI - AI.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneum.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1 - 1983, to Sept 15, 1983, that (I) (we) last saw the deceased alive on Sept 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. S. Curtis M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 15 Sept 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. G. ARTHUR, M.D.					22e. ADDRESS 3180 St Berlin Md. 21811						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-18-83		23c. NAME OF CEMETERY OR CREMATORY New Hope Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Willards, WICOMICO, MD					
24. FUNERAL DIRECTOR NAME Charles W. Hartman					ADDRESS Salisbury, Md		25a. DATE REC'D. BY REGISTRAR SEP 20 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

Sept. 8. 1914

Homeville

Farland Worcester Berlin

Stamford Scott

21-10-201 David Lewis Jr. Cambridge, MA

David Lewis Jr.
21-10-201

2020

From Union
to Arthur W. 2020

Wilmington, Delaware

New York City

First

Arthur W. 2020

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, INFORM THE CHIEF OF THE FUNERAL HOME, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PREPARE FOR BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25596

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
EARL C. WILLIAMS		9 24 1983		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
MALE	WHITE	OCT. 13, 1914	64 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	UNITED STATES		Worcester MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Pocomoke	Pocomoke River	HANDY MAN			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	WORCESTER	Pocomoke	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RURAL 21851	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
JOHN A. WILLIAMS	EMMA GIBBONS	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> WW II			
16a. SOCIAL SECURITY NO.	17. INFORMANT	17. ADDRESS			
218-30-5043	STANLEY L. WILLIAMS	PO BOX 2 SELBYVILLE, DEL.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9-24- 19 83	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		Subject fell from bridge into water.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	bridge-Rt. 13	Pocomoke River	Worcester		MD.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		M.D. Assistant MEDICAL EXAMINER		9-29-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	OCT 4, 1983	WESTVIEW CREMATORY	WESTVIEW	BALTIMORE	MD
24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D. BY REGISTRAR		
WATSON & MELSON F.H.	185 LINDEN AVE Pocomoke City, MD.		OCT 7 1983		
		25b. REGISTRAR'S SIGNATURE			
		John J. Connel			

ORIGINAL

DO NOT WRITE

DATE: 12-13-54

RECEIVED

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

Very truly yours,
J. Edgar Hoover
Director